Anthem Blue Cross
PORAC Prudent Buyer PPO Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 – 12/31/2017
Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.anthem.com/ca** also www.porac.org/insurance-and-benefits/or by calling PORAC: **1-800-288-6928.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO Providers: **$300** Member/**$900** Family For Non-PPO Providers: **$600** Member/**$1,800** Family Does not apply to Preventive Care, Office Visit Copayments and Prescription Drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered service you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, **For Medical Services/Expenses:** Your combined maximum for all medical services from a Participating PPO or Non-Participating Provider is: **$4,500** Member/**$9,000** Family **For Pharmacy/Prescription Expenses:** **$2,650** Member/**$5,300** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.

Questions: Call 1-800-288-6928 or visit us at **www.anthem.com/ca** also **www.porac.org/insurance-and-benefits/**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf** or call 1-800-288-6928 to request a copy.

Does this plan use a network of providers?	Yes, See **www.anthem.com/ca** for a list of participating providers.	If you use an in-network doctor of other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, our in-network doctor of hospital may use an out-of-network **provider** for some services. Plan use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No, You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or	Primary care visit to treat an injury or illness	**$20** Copay/Visit	***10%** coinsurance of limited fee schedule	----------none----------
	Specialist visit	**$20** Copay/Visit	***10%** coinsurance of limited fee schedule	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
clinic	Other practitioner office visit	Chiropractor & Acupuncturist **$20** Copay/Visit	Chiropractor & Acupuncturist ***10%** coinsurance of limited fee schedule	Chiropractic Coverage is limited to 20 visits per calendar for in-network. Chiropractic visits count towards your physical and occupational therapy limit.
	Preventive care/ screening immunization	No Cost Share	***10%** coinsurance of limited fee schedule	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Lab & X-Ray-Office **10%** Coinsurance	Lab & X-Ray-Office ***10%** coinsurance of limited fee schedule	----------none----------
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available	Generic drugs	**$10** copay/prescription at retail; **$20** copay/prescription at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	**$25** copay/prescription at retail; **$40** copay/prescription at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	**$45** copay/prescription at retail; **$75** copay/prescription at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Covers up to a 30 day supply (retail prescription); 31-90 day supply (mail order prescription)
	Specialty drugs	**$25** copay/preferred drug prescription retail; **$45** copay non-preferred drug prescription retail.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Pre-authorization required 30 day maximum supply No mail order available.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Physician/surgeon fees	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
If you need immediate medical attention	Emergency room services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Emergency medical transportation	**20%** Coinsurance	**20%** Coinsurance	----------none----------
	Urgent care	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Pre-authorization required.
	Physician/surgeon fee	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Mental/Behavioral health inpatient services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Pre-authorization required.
	Substance use disorder outpatient services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Substance use disorder inpatient services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Pre-authorization required.
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Delivery and all inpatient services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Subject to pre-authorization review. Coverage is a combined total of 100 visits, In or Out of network/per calendar year.
	Rehabilitation services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Coverage is limited to 20 visits combined for Occupational, Physical therapies including Chiropractor services. Additional visits may be authorized.
	Habilitation services	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	Subject to pre-authorization review. Coverage is a combined total of 100 visits, In or Out of network/per calendar year.
	Durable medical equipment	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
	Hospice service	**10%** Coinsurance	***10%** coinsurance of limited fee schedule	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (Unless you have been diagnosed with diabetes. Consult your formal contract of coverage.)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (For morbid obesity, consult your formal contract of coverage.)
- Chiropractic care
- Hearing aids (Coverage is limited to one hearing aid per ear every three years.)
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

Your Rights to Continue Coverage:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights, maybe limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan,. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-737-7776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:
Anthem Blue Cross 1-800-288-6928 P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: PORAC Unit
Additionally, a consumer assistance program can help you file your appeal. Contact:
California Department of Managed Health Care Help Center
980 9th Street, Suite 500 Sacramento, CA 95814
(888) 466-2219 http://www.healthhelp.ca.gov
helpline@dmhc.ca.gov

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Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,370
- **Patient pays** $1,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$20
Coinsurance	$700
Limits or exclusions	$150
Total	**$1,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,300
- **Patient pays** $1,100

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$600
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,100**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network p**roviders**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.